

## **Summary of Physician-Assisted Suicide Proposal Introduced by Rep. Frank Boyle & Senator Fred Risser**

### **Individual requesting physician-assisted aid in dying must be:**

- At least 18 years of age.
- Resident of Wisconsin.
- Suffering from a terminal disease (defined as an incurable and irreversible disease that will cause death within six months), confirmed by two doctors.
- Of sound mind & not incapacitated.

### **Procedure for request to physician:**

- First request must be made orally.
- Not fewer than 15 days later, the patient must again make the request in writing, signed in the presence of 3 qualified witnesses.
- If the patient is in a health care facility, at least one of the witnesses must be a patients' advocate designated by the Board on Aging and Long-Term Care.
- After request is filed, patient must make a second oral request.

### **Witnesses must be at least 18 years of age and cannot be any of the following:**

- Related to the patient by blood, marriage or adoption.
- An individual who has knowledge that he or she is entitled to or has a claim on any portion of the requester's estate.
- Directly financially responsible for the requester's health care.
- An individual who is a health care provider who is serving the patient at the time of the witnessing; an employee, other than a chaplain or a social worker, of a health care facility in which the requester is a patient.

### **The physician must:**

- Inform the patient of his or her diagnosis & prognosis.
- Inform the patient of the probable results of taking the prescribed medication and alternatives to doing so.
- Refer the patient to a consulting physician for review.
- Refer the patient to a psychiatrist or psychologist for review, if that person is suffering from a psychiatric or psychological disorder.
- Certify that the statutory requirements have been met.
- Ask the patient to inform his or her next of kin about the request.
- Offer the opportunity for the patient to revoke the request.

Open letter to Wisconsin Right to Life Legislative Director

Dear Susan Armacost:

Your statements opposing Sen. Fred Risser's and Rep. Frank Boyle's "Death with Dignity" bill indicate you did not research how the law has been implemented in Oregon. As the executive director of the statewide organization that has stewarded more than 1000 qualified, terminally ill Oregonians through the safeguards and guidelines of our law please allow me to address your specific concerns.

Not one person who qualified to use the law requested to use it because they believed they had a "duty to die." All of them had a "will to live" as long as possible. The average length of time from when these individuals contact us to their death by the lethal medication is 116 days; this can hardly be considered rushing to die after having received a six month prognosis.

Of the more than 1000 Oregonians our organization has been honored to serve and who began the process to use our law, only 250 actually took the medication that ended their suffering. Not one of them consumed the medication out of depression or a duty to end their life.

More than 84% of those who took the medication were enrolled in hospice care at their death. This refutes your claim that they are not receiving the best care. More than 95% had secondary education or higher, in fact 70% had a college degree or higher. The top three reasons they gave for taking the medication was loss of autonomy, fear of loss of control and dependence on others for care. Everyone who has taken the 5-6 ounce lethal mixture has died peacefully, with family or friends present, and at peace with their decision. These facts alone refute your claim that these are weak and frail people. They are among the bravest, strongest willed, deeply spiritual people I have ever met.

Of the more than 1000 Oregonians we have worked with, more than 900 self identified as being religious or spiritual, 434 acknowledged as voting Republican and 439 as voting Democrat, 98% had health insurance, 538 were males, and the ages ranged from 20 to 109 with the average age of 69. These are fiercely independent people who do not choose this method because they do not wish to live, they choose it because they know their death is imminent and they wish to face it on their terms with dignity and grace.

Today's accepted Hippocratic oath states a physician will *practice and prescribe to the best of my ability for the good of my patients, and to try to avoid harming them and never to do deliberate harm to anyone for anyone else's interest.* Those physicians who prescribe medication for their terminally ill and suffering patients are doing so "for the good of their patients" and if they allow them to continue to suffer they believe it would be doing harm to them.

A law that allows one to die with dignity brings hope to all. If one is terminally ill, has 2 physicians say they will likely die within six months from their illness and the person goes through the waiting period, makes the required 3 requests for assistance, is mentally competent and is able to self administer the medication, then they are given the strength to face death with the knowledge that there is a safety net for them if the suffering becomes unbearable. Please let others have this choice, even if you do not wish to exercise it.

Please check your facts before you speak for those of us who have the "will to live" life to its fullest, but want the right to die with dignity when our death is near.

Sincerely,

*George Eighmey*

Executive Director

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*Compassion*, through its network of professional volunteers, offers consultation about all end-of-life options to terminally ill, adult Oregonians and their families. We provide free consultation on pain and symptom management, hospice care, and for mentally competent adults who make an enduring and voluntary request, we provide information about hastening death to avoid further suffering.

January 15, 2008

To all of my physician colleagues who are deliberating on the question of doctor-assisted suicide in Wisconsin.

I am an internal medicine physician practicing in Portland, Oregon, and I would like to share with you a story about one of my patients.

Recently, I was caring for a 76 year-old man when I made the diagnosis of malignant melanoma, found a metastasis in his shoulder, and referred him to both medical and radiation oncologists for evaluation and therapy. I had known this patient and his wife for more than a decade. He was an avid hiker, a very popular hobby here in Oregon. As he went through his chemotherapy and radiation therapy, he became less able get out and hike, which caused a depression, documented by his radiation oncologist.

At his final visit with his medical oncologist, he expressed a wish for doctor-assisted suicide. Rather than taking the time and effort to address his depression, or ask me to respond to his depression as his primary care physician and as someone who knew him, the medical oncologist called me and asked me to be the "second opinion" for his assisted-suicide. The oncologist told me that secobarbital, a barbiturate used in anesthesia, "works very well" for patients like this and had prescribed this many times.

My reply was that assisted-suicide was not appropriate for this patient and that I did NOT concur. I was very concerned about my patient's mental state, and I told the oncologist that that addressing his underlying issues would be better than simply prescribing a lethal medication. Unfortunately, my concerns were ignored, and two weeks later my patient was dead from a lethal overdose prescribed by this oncologist. I obtained a copy of his death certificate which listed the cause of death as melanoma.

The public record is not accurate. My patient did not die from his cancer, but at the hands of a once-trusted colleague. This experience has affected me, my practice, and my understanding of what it means to be a physician. What happened to this patient, who was weak and vulnerable at the end of his life, raised several important questions that I have had to answer, and that you in Wisconsin need to understand as you deliberate this question for your citizens:

1. Who can you trust? If you send a patient to a colleague and expect excellent care, do you have to specifically ask "Will you kill my patient when he becomes depressed at end of life?"
2. What does the request for 'assisted-suicide' mean? Suicidal ideation used to be interpreted as a cry for help, and the only help my patient received was a lethal prescription intended to kill him.
3. What could I have done to help this patient? I had referred him to a specialist, a person who I trusted, and the outcome proved to be fatal. My patient's needs were not met. If my colleague had bothered to find out more about him and worked with him to treat his depression, or had my colleague taken time to help my patient find meaning and new ways to function, perhaps things would have turned out differently.

Physicians and health care workers in Wisconsin, is this where you want to go? Is this what you want to become? Please learn the real lesson from the Oregon experience of doctor-assisted suicide. Despite all of the so-called "safeguards" in our assisted suicide law, numerous instances of coercion, inappropriate selection, botched attempts, and active euthanasia have been documented in the public record. This however is not the worst of it. In my opinion, the tragedy of Oregon is that instead of doing the right thing, which is to provide excellent care, patient's lives are being cut short by physicians who are not addressing the issues underlying patient suicidality at the end of life. This change in the direction of our profession, after 2400 years of "Do No Harm", has me concerned. This should concern Wisconsin as well.

Respectfully submitted,

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January 23, 2008  
Joy Kragenbrink on Senate Bill 151

Hello my name is Joy Kragenbrink. I'm opposed to Senate Bill 151. Before I tell you why, let me introduce you to my sister, Melissa, who is going to speak for me because I want to be clearly understood. I want to make it quite clear though, that these are my words.

Life has value and meaning even when it is lived in pain. I'm passionate about this because I live in almost constant pain or discomfort. And have my entire life. Yet I am able to encourage the people around me with my happy countenance. I look people in the eye and smile. This improves the quality of their day, and mine! Here are three reasons why I'm opposed to Senate Bill 151: this bill undermines the value of life, every day of a terminal patient's life is important, and a lifespan is unpredictable.

First, this bill undermines the value of life. There can be a fine line between being terminally ill and chronically ill. As a disabled person, I know that complications from my disability could cause my condition to become terminal. Actually, this applies to a lot of people with disabilities who I know. This is a vulnerable segment of society since many disabled people already feel they are a burden to their families and caregivers as well as society. If this bill is passed, people in the disabled community could begin to feel a subtle pressure to relieve society of the burden they now perceive their life to be. They may feel like it is their duty. Passing this bill would undermine the value of life.

My second point is that the remaining days of a terminal patient's life are important. I would like to tell you about my dad. He died a painful death of cancer at thirty-one years old. This was after years of fighting for his life. I watched him influence the lives of the people around him for good during this time. Every moment that he lived was another moment that he gave to me. I remember him because he fought for his life. He taught me that life is to be treasured, pain and all.

My final point is that doctors do not always accurately predict a patient's lifespan or the subsequent quality of life. This is why. Four people in my immediate family survived and lived full lives far beyond a doctor's expectations. First, I was born three months premature and weighed one pound twelve ounces at my lowest. I also had a brain hemorrhage shortly thereafter. In the eyes of my physician, the odds of my survival were extremely slim and there would be no subsequent quality of life if I actually survived. My twin brother, Luke, had even more complications than I did. At two weeks old he had open heart surgery and his lungs were repeatedly collapsing. Like me, he had low odds of survival. He is now living a perfectly normal life. At our birth, my mom was also not expected to survive due to uncontrollable hemorrhaging. Yet again, contrary to doctors' expectations, my mom miraculously survived. The forth, and final example of life being sustained beyond doctor's expectations is, as I mentioned earlier, my dad. He lived years beyond what his doctors expected. All four of us are grateful for each day we have lived. This tells me that our quality of life is pretty good even though none of us were expected to survive.

As I read this bill, I kept seeing the phrase "die with dignity". I can't help but wonder why the focus is on "death" with dignity. Instead we need to focus on pouring our energies into ways of making a person's last days of life comfortable and dignified. Even though I am physically disabled, even though I am not able to do the things most people can do, and even though I live with pain, my life impacts the people around me, and I will continue to do this until the day I die. I chose to LIVE with dignity.

I urge you to oppose Senate Bill 151. Thank you.

Thank you for the opportunity to speak here today. My name is Dr. Patrick Sura. I am a Family Physician in River Falls Wisconsin and have been in practice for over 20 years. I am here to give some thoughts and testimony in opposition to Senate Bill 151, the bill that deals with physician assisted suicide. My first observation is that this legislation is not needed. The so called "Death with Dignity" Bill has been unnecessary for the past 14 years that some form of this bill has been introduced and debated. There is no outcry for this legislation. Physicians do not want this bill. This bill is designed to limit its victims to over age 18 of sound mind and "terminal" diagnosis. The supposed safeguards of this bill are merely stepping stones to an expansion of the right to die. Our country establishes rights for our citizens and works at not allowing discrimination to occur. The "rights" of one group will be expanded to other groups in due time. The Slippery Slope of this bill will occur. What is initially hailed as a "Right to die" for few will become an "obligation to die" for many.

The collision of morals and ethics with fears, feelings, and finances will lead to blurring of boundaries and increased legislative challenges as well as an erosion of the trust in the care provided by the many fine and honorable and ethical physicians in this state. The publicity of this bill seems politically motivated and diverts time and money from more important issues and opportunities. Let's see a bill to fund critical projects such as Free Health clinics like those functioning in River Falls and Menomonie and other communities. Let's see funding for hospice and palliative care and address other issues for the uninsured and the needs of our vulnerable children. We would see bipartisan support and voter support as well as support from the medical community for the true needs of our state. Stop funding "pet projects" of powerbrokers in government and if you are going to raid the Patient compensation fund to balance the budget at least earmark the money for the health related issues of our state residents.

In my personal experience of 20 years as a Wisconsin trained and licensed physician includes dealing with patients requesting assistance in hastening their death. Some of those patients have been "terminal" while others have simply grown tired of living, of feeling burdensome to others, or simply tired of battling disease processes and the frailties of aging. Most of these requests are a call for some help from caring providers. I have treated a 60 year "Terminal male" for his depression after he wanted his life to end. He watched his grandson graduate from college and his granddaughter get married. Would it have been a death with dignity- and yes a psychiatrist is supposed to evaluate every request but this diagnosis can be missed. And do depressed people have less rights than the non depressed and can we discriminate against the free will of someone in pain from someone in possibly worse pain from Rheumatoid arthritis ?? A slippery slope or is it irrational fear mongering?

Another patient is a 52 year old woman with pain she can no longer live with and asks for help because she does not want to shoot herself. A Cry for help –not a desire to die!! She gets pain control and lives several additional months and spends valuable time with her family and her faith. Medicine can control pain in nearly 100% of cases. Hospice physician and palliative care workers are not asking for help to terminate their patients.

Recently I helped care for a 48 year old woman dying of breast cancer after a 10 year battle with the disease. She outlived her "Terminal " diagnosis several times and ultimately died a very peaceful and

natural death in the presence of her family. This was achieved by caring and compassion from nurses, social workers, clergy, and physicians. The dying process was inevitable and it is a very emotionally draining experience but allows friends and family to “say goodbye” in a natural way without intent to hasten death by intervention. Many tears were shed by relatives and simply by acquaintances but there was a peace that everyone felt about the life that had ended through a natural process.

Trust in healthcare providers and physicians is critical and this bill undermines the current ethical standards that physicians should be accountable to from their profession and its guiding associations. There will be nurses or doctors that would embrace this bill (usually for a profit) and want to be known as “Agents of Mercy” or the next Dr. Kevorkian but that does not make it right.

Most doctors work hard at treating patients with kindness and compassion and a respect for life and want everyone to live a full and productive and comfortable life. This law is in conflict with what is taught in medical schools across the country. Everyone including legislators and lawyers can help to make the dying process an experience that should not be feared but embraced as a natural end to our life on Earth. We are all “Terminal” and deserve to “Die with Dignity”. We cannot legislate that right. We should support the people and the processes that already work with families and patients to provide this every day.

I could tell stories of patients that have helped me to develop as a physician and to improve my care of others. Educating physicians in End of Life care may need to be improved so we can help patients to enjoy their life and be loved by a caring family that will let them pass beyond this earth when the time comes. We should not be choosing the time as that raises additional ethical issues of reasons that others may choose to hasten a loved one’s death. Not part of the bill and I am sure there are some who disagree with me.

I have a friend and physician colleague who was diagnosed with brain cancer of the worst type and prognosis. He outlived his initial “Terminal” diagnosis and was working as a physician again in a profession he loved. He then had an inevitable recurrence and was unable to work and faced additional physical and emotional challenges. He was kept at home with the aid of a loving wife and 4 children. His disease progressed further but his faith never wavered. I had the privilege of travelling with him on I believe his last independent outing away from his family. We drove to Green Bay to see the Packers play his favorite team, the Detroit Lions. As we drove we discussed his life and his approaching death. He was an amazing person yet asked for minimal assistance. At the game we enjoyed the aura and the atmosphere and the rain at Lambeau Field. He was not a dying man at that stadium but another football fan living a Dream. Would a law legalizing Physician assisted suicide change the expectation for patients or would society change its expectations to promote “easing a family’s burdens” by hastening one’s death?? Would it alter the dying process and the safeguards and the rights of individuals to seek assistance?? My friend died a very dignified and peaceful death surrounded by his family. Others do the same every day.

I encourage the legislators to reject the propose law and all of its tenets. Realize the risks of this bill and for citizens of this great State. We look to you for leadership and you will be accountable for your

Death With Dignity Bill Hearing –January 23,2008

actions. I appreciate the opportunity to voice my opinion on this issue and would like to see time and energy and money spent on other issues. Please vote No for Senate Bill 151. Thank you.

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COMMITTEE ON PUBLIC HEALTH, SENIOR ISSUES, LONG TERM CARE AND PRIVACY.  
SENATE BILL 151  
Assisted Suicide and Euthanasia  
January 23, 2008

Chairperson and ladies and gentleman of this committee. I count it a great privilege to be able to speak my opinion before you today on this very important matter. As Executive Director for Baptists for Life of Wisconsin, as a Pastor, as an American and as a resident of this great State of Wisconsin I am honored to be here today.

I speak in opposition to SB 151 for several reasons. Down through the centuries, until recently, medical doctors took the Hippocratic Oath which says "First Do No Harm." Doctors were to comfort and to heal, and not to kill. To give medication for one to take one's own life is nothing more than "Terminal Sedation" or a form of killing or premeditated murder. If we tolerate just a little bit of deliberate death, albeit with "safeguards," we contribute to the "culture of death." Terminal sedation does not offer patients more control at the end of life. It offers only death. I quote from a pamphlet entitled "Euthanasia, when the doctor kills the patient. By J.C. Willke. MD.

"Patients, who are dying, do go on to die. While the proponents of euthanasia constantly speak about such cases, these are not their target at all.

They are, rather those who somebody thinks ought to die, but who won't . . . the biologically tenacious. Commonly, such people are not in pain, and not on life support systems but are, by some judgments, a burden to society. These are people with strokes, multiple sclerosis, Lou Gehrig's disease, head injuries, quadriplegia, etc.<sup>1</sup>

Holland legalized euthanasia, which has now become almost routine in that country. Of the 130,000 people who die annually in Holland, up to 20,000 are either killed or helped to die by doctors, and as many as one-half did not ask to die. The Dutch Patient's Association placed a warning in the press that, in many hospitals, patients are being killed without their will or knowledge, or the knowledge of their families, and advised the patients and their families to carefully inquire on every step in the treatment, and when in doubt, to consult with a reliable expert outside the hospital.<sup>2, 3, 4.</sup>



I also oppose this bill because though most doctors do an excellent job in diagnosing illness and prognosis, they are frequently wrong when a person will die. Many of us know of people where the medical profession gave the patient a year to live, and they died within a month, or the doctor gave the patient six months to live, but they have been healed of their disease and are alive and well two years later. .

How many people ask to die so as not to be a burden upon their loved ones? How voluntary is voluntary when the patient feels unspoken pressure from family members and loved ones to not be a financial, emotional or time burden to anyone? Because of the rising costs of health care and the rising number of elderly and those of us over 65 years of age, good palliative care may decrease if assisted suicide or euthanasia are an option. – In Holland, comforting and easing care to terminally ill has largely disappeared.

Patients can be misdiagnosed, and could make an irreversible decision to die based on the wrong information. A study in the Netherlands found that 65% of family physicians are of the opinion that a doctor may offer the choice of euthanasia to a patient who has not asked for it. Patients are often influenced by their doctor, and a vulnerable patient may feel there are not other alternatives if his or her doctor recommends death. Patients with terminal or serious illnesses change their minds. If they don't feel well, they want to die, if they feel well they want to live. Patients may become depressed with their diagnosis and request death, not knowing that their quality of life can improve with proper care.

If we in the State of Wisconsin endorse assisted suicide and euthanasia, we will be teaching violence to an already violent society. Call it what you may, but assisted suicide and euthanasia are nothing less than a violent crime of pre-meditated murder, though legislation may make it "legal."

We have heard the arguments which support "embryonic stem cells research" telling us of its great potential to find cures for diseases, that a cure for some disease or injury may be "just around

the corner.” Whose to say that the a cure for the patients illness or disease is not “just around the corner.”

Rather than giving a patient the choice to kill himself or herself, we can and must assure them that their worst fears will not be realized.

1. They need not to suffer nor die in pain, as there is proper pain management available
2. They will never be a burden to anyone, as someone will be there with love and compassion to minister to them.
3. They will not die alone, as someone will be there with them.

Killing is not caring, and assisted suicide and euthanasia are marked by a lack of commitment, promising only that death will be swift and painless and final. I must remind each of you that each one of you are terminally ill, we are all going to die someday. And the Word of God the Bible says *“It is appointed unto man once to die, and then the judgment.”* Hebrews 9:27 God is the One who decides when it’s someone’s time to die. *“Seeing his days are determined the number of his months is with thee, thou hast appointed his bounds that he cannot pass* (Job. 14:5)

Mark Blocker says it well “We should not permit tragic circumstances to become opportunities to shape the concepts of autonomy and human dignity into rationalizations that justify “mercy killing.” It is unwise to press for legalization of physician-assisted suicide when so few people are aware of alternatives like good hospice. In fact, focusing all our effort on the debate whether or not we should legalize the practice misses the most important issue, how to improve care for dying individuals. . . . Should we acquiesce to the clarion call to make physicians into killers, we will not only abandon our love ones and our duty to care for them, but we will have unleashed the worst tendencies of modern life- the tendency to cushion selfishness and inhumanity under the soft pillow of compassion and humanitarianism. Are we going to spend all our effort, time and resources in public policy and courtroom litigation, and use so little of our time, energy and financial resources to improve care for the dying?<sup>5</sup>

Are we as a society going to set a standard for “quality of life?” and then when that “quality of life” is no longer possible but it is actually a benefit to bring about death, as to remain alive is a burden to oneself, and to society?

My fellow Wisconsinites, the logic which supports abortion, that a baby is not needed, or is severely "defective" has taken us down the slippery slope to physician assisted suicide and euthanasia for others lacking "quality of life." We are becoming no better than Hitler's Nazi Germany where people were murdered and done away with because they were not wanted, needed or were inferior.

If death is an acceptable solution to unwanted, unwelcomed or deformed pre-born babies, it is an equally valid response to pain and suffering at the end of life. The State has a compelling interest in protecting human life, we provide policeman to protect our cities and make our streets safe, and that interest will be lost if we begin to recognize privately arranged killings.

Lawmakers, if you legalize assisted suicide and euthanasia, do not have a doctor do it. He is to "do no harm." Rather have an executioner do it.

When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assisted suicide generally disappears.

Committee persons, I stand in opposition to SB 151. Thank you for listening to me and/or reading my testimony today. If you have questions, I will be glad to try to answer them.

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#### Footnotes

1. J.C. Willke. *Euthanasia, When the doctor kills the patient*. Hayes publishing Company, Inc. 6304 Hamilton Ave., Cincinnati, Ohio 45224. p.3.
2. R. Fenigsen, "Involuntary Euthanasia in Holland", Wall Street Journal, Sept. 30, 1987.
3. J. Willke, "How Doctors Kill Patients in Holland", Nat'l Right to Life News, May 23, 1989
4. J. Bopp et al. "Euthanasia in Holland", Issues in law & Medicine, vol. 1, no. 1. Spring '89, pp. 455-487.
5. M. Blocker, "The Right to Die, Moody Press, Chicago, 1999. p.13.

My name is Robert Woodson. I am a Professor of Medicine Emeritus at the University of Wisconsin School of Medicine and Public Health. I feel distinctly privileged to address this Committee today on the proposed Senate Bill 151.

As in most areas where members are called on to legislate, one easily recognizes that this issue is complex, with advantages and disadvantages on both sides.

I have spent my professional life in the subspecialty of Hematology. This is the discipline that cares for malignancies of the blood and blood forming organs – notably leukemia, Hodgkin's disease, the lymphomas, multiple myeloma, and others.

Happily, in 2008, we are able to cure a growing percentage of these malignancies with drugs. However, the majority of our patients still eventually succumb. The commonest pattern is complete remission with initial treatment, often with several years of excellent health, then a relapse, then more treatment and benefit, then relapse after a shorter period of time. Thus we have the enormous privilege of working with people over many years and have become wonderfully good friends with them and their families. We care for each other deeply. But the road we walk together is difficult, and it almost always becomes more difficult with time.

Yet, in the 40 years that I have been doing this, I have received only one request for termination of life. Just one, in a specialty that deals principally with malignancy. That one request was from an elderly woman. This was probably 20 plus years ago, well before Oregon, and we explained that what they were asking for was not possible. So we took care of her compassionately, lovingly until the end came. Importantly, I was not able to figure out how much of this request was truly her own idea and how much she was influenced by her daughters, who were very adamant.

[What I have gained from my work is a keen appreciation of the unique benefits that accrue to families facing death in terms of expressing love to each other. This may be a tough time, but is also a precious time. Some families are in need of reconciliation, and I have witnessed embraces after estrangement. Every family has bonds that can be strengthened through extending love to each other and observing, up very close, a reality of life. So I never miss the opportunity to talk with people about the unique privilege of allowing suffering and approaching death to bring them together as a family in a new way. And I marvel as I watch it unfold. While I can recall only one family that requested assisted suicide, I could not begin to count how many have experienced love and healing and wonderful closure. It would be wrong for us to offer the option of preempting this time. It is as much a part of life as birth, and we should not actively interfere with it. Furthermore, and unlike most of human history when people coped, we have the real gift of morphine to give, and give generously, when it is needed. And, unlike ending life, the dose of morphine can be decreased every now and then, when important communication needs to occur. Morphine does not leave guilt in its wake.

And I should quickly add that being against physician-assisted suicide does not mean that one has to engage in measures that prolong life. Many patients opt against more treatment when the chance of major benefit is slim, and it is with this doctor's blessing.]

[Another point. Every time I pass a certain store here in Madison, I am reminded of the owner's wife, a woman in her 40s with acute leukemia. We discharged her to die at home at her request, her bone marrow still showing lots of leukemia long after the final chemotherapy ended. There was no hope. To my great surprise, she turned up in my clinic several years later. She had been trekking in the Himalayas in Nepal! If she asked for help in ending her life, any doctor would have thought there was zero chance of recovery and signed the paper. Doctors regularly see the unexpected.]

Another point. You will find that most doctors will have nothing to do with this. Why? Because we want to be our patients' advocates. We don't want them to worry that we will abandon them, that we will have a second agenda of holding down health costs. We want them to trust us.

Now my last and most important point. What troubles me the most about physician-assisted suicide is the likelihood that some persons will feel an obligation to select this option. Why? Because of their own generosity, or money, or because of pressure from a dysfunctional family, or pressure from third party payers. It is a certainty that this will happen once the door is open. And we will never be able to determine when people are going along with the idea when they don't want to. There will be a maze of dynamics

that no neutral person can penetrate. All of you know by now that innocent people have wound up on death row.

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In summary, for all of the above reasons, I believe the risks of this legislation significantly outweigh its benefits.

Thank you.

Testimony Before the  
The Senate Health, Human Services, Insurance,  
and Job Creation Committee

January 23, 2008

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## INTRODUCTION

Thank you for the opportunity to address this committee on behalf of Not Dead Yet, a national disability rights group that opposes legalization of assisted suicide and euthanasia, and thank you also to the Wisconsin Not Dead Yet members whose circumstances prevent them from being here.

I'm especially grateful to be here today because of the ways the political culture war has often been used to exclude and marginalize the disability community in the public debate on these issues. Not Dead Yet formed in 1996 when grassroots disability activists saw Jack Kevorkian acquitted in the assisted suicides of two disabled women. We recognized the need to stop a well-funded and media savvy political movement that had been building its successes over the dead bodies of people with disabilities for over a decade.

And we'd like to emphasize the bipartisan nature of disability concerns. While conservatives disagree with assisted suicide, they have their own way of rationing health care to our detriment. For those who depend on publicly funded health care, federal and state budget cuts pose a very large threat. In fact, some of the cuts we've faced, such as in states that have cut Medicaid services for people who use ventilators or feeding tubes, are nothing less than back door euthanasia. So we're speaking to all parties here.

## WHAT'S DISABILITY GOT TO DO WITH IT?

Assisted suicide is supposedly about terminal illness, not disability, so many question disability groups "meddling" and trying to "take away" what they see as the general public's right to choose physician assisted suicide.

Most people realize that they have a good chance of becoming terminally ill before their life is over. But many don't realize that they have an almost equal likelihood of passing through stages of chronic illness and disability before they are "terminal."

The disability experience is that people who are labeled "terminal," based on a medical prediction that they will die within six months, are — or almost inevitably will become — disabled. Furthermore, virtually all so-called "end-of-life care" issues — access to competent health care, adequate pain relief, in-home personal care and flexible, consumer-directed supports, peer counseling, family support — have been disability rights issues for decades.

The question we should ask is why do some people ask for assisted suicide and some doctors choose to provide it? In fact, although intractable pain has been marketed as the primary reason for enacting assisted suicide laws, the reasons

Oregon doctors actually report for issuing lethal prescriptions are the patient's perceived "loss of autonomy," "loss of dignity" and "feelings of being a burden." These feelings arise when a person acquires physical impairments that necessitate relying on other people for help in tasks and activities formerly carried out alone. These are fundamental disability issues.

Unfortunately, popular culture has done virtually nothing to educate the public about how people with severe disabilities actually live autonomous and dignified lives. Our lives are portrayed as tragedies or sensationalized as heroism, but the real life issues and coping methods that most people will need if they live long enough are left out of the picture. No wonder people who acquire disabilities in the course of a significant illness or through accidents so often see death as the only viable solution.

### THIS IS NOT ABOUT THE EXISTING RIGHT TO REFUSE TREATMENT

Physician assisted suicide should not be confused with the issue of whether doctors can force unwanted medical procedures on us. It's important to be clear that the right to refuse unwanted medical treatment was affirmed by the U.S. Supreme Court in 1990, long ago.

### THE PROBLEM OF PHYSICIANS AS ASSISTED SUICIDE'S GATEKEEPERS

Proponents of legalized assisted suicide assert that laws and regulations will help prevent abuses. But the law's only ironclad safeguard is the civil and criminal immunity granted to physicians. This is the lowest culpability standard possible, even below that of "negligence," which is the minimum legal standard governing other physician duties. The Oregon safeguards are set up to fail.

The individual's request for assisted suicide is necessary, but not sufficient, to get it. In effect, the Oregon Law gives physicians the power to judge whether a particular suicide is "rational" or not based on his or her prejudice or devaluation of the individual's quality of life, and then to actively assist certain suicides based on that judgment. This should be viewed as a violation of the Americans with Disabilities Act, which prohibits discrimination based on disability.

As Oregon reports on physician-assisted suicide make clear, the state has not been able to assess the extent of non-reporting or noncompliance with the law's purported safeguards, but only obtains brief interviews with physicians who file their paperwork. There are no enforcement provisions in the law, and the reports themselves demonstrate that non-terminal people are receiving lethal prescriptions. As the Oregonian stated in March 2005 in "Living with the dying 'experiment,'" examining the case of David E. Prueitt who woke from his assisted suicide after two weeks and did not try again, "The rest of us . . . still need an answer from a system that seems rigged to avoid finding one."

## EXISTING FUTILITY POLICIES ALREADY INVOLVE INVOLUNTARY EUTHANASIA

Another big reason for concern about physicians as gatekeepers in the context of active assisted suicide is that they already engage in practices involving involuntary passive euthanasia under futility policies. A 1999 Journal of the American Medical Association article recommended that hospitals develop futility guidelines, whereby the hospital takes the patient and family through so-called hearings with ethics committees to persuade them to refuse treatment and, if that doesn't work, they may just deny treatment anyway, as "futile." Financial pressures have grown to the point that, increasingly, physicians make medical decisions to withhold treatment in open and direct opposition to the decision of the patient, their surrogate or their advance directive under what are called futility policies.

Basically, the bioethicists have warped so-called "end-of-life" care into life-ending non-care for some people. The bioethicists have had hundreds of millions of grant dollars to work with, and they've used it to build public policies on guardianship and futile care into a steamroller that's decimating the civil and constitutional rights of people whose lives are viewed as too marginal or costly to support. Once assisted suicide is legal, what is to prevent a shift toward involuntary practices in this context as well?

## FALSE CHOICE, FORCED CHOICE

The third year case of Kate Cheney, reported in detail in the Oregonian (Barnett, E.H. "Is Mom Capable of Choosing to Die?" 10/17/99), provides an important example of disability concerns. Mrs. Cheney's physician was concerned that she had early dementia and that her daughter might be pressuring her toward assisted suicide, so he referred her for a psychological consultation. The first consultant found that Mrs. Cheney's assisted suicide would not be voluntary because of pressure from her daughter, but a second referral concluded that her suicide would be voluntary in spite of pressure from her daughter. The lethal prescription was issued, but Mrs. Cheney didn't take it until after her family put her in a nursing home for a week so they could have respite from care-giving. So Mrs. Cheney was presented with the following so-called "choice": be a burden on family, go to a nursing home, or commit suicide.

Why, disabled people ask, do we see so many news stories lately about the burdens we impose on our caregivers, and so few articles about the nation's ability to provide the long-term care people really need and want? If the values of liberty dictate that society legalize assisted suicide, then legalize it for everyone who asks for it, not just the devalued old, ill and disabled. Otherwise, what looks like freedom is really only discrimination.

## ELDER SUICIDE

We also think we should look at the fact that Oregon has the fourth highest elder suicide rate in the country. Perhaps one of the most important questions raised by the Oregon experience is whether legalizing these individual assisted suicides has a broader social impact. Does it matter that a society accepts the disability-related reasons that people give for assisted suicide, the supposed loss of dignity, then declares the suicide rational and provides the lethal means to complete it neatly? Does it harm people who are not deemed eligible for assisted suicide under the current version of the law but still experience the same sense of loss? In the face of constant social messages that needing help in everyday living robs one of dignity and autonomy, makes one a burden and justifies state sponsored suicide, maybe Oregon's elders have taken this disgusting and prejudicial message to heart.

What looks to some like a choice to die begins to look more like a duty to die to many disability activists.

## CONCLUSION

Disability concerns are focused on the systemic implications of adding *assisted* suicide to the list of "medical treatment options" offered to seriously ill and disabled people. The disability rights movement has a long history of healthy skepticism toward medical professionals who are assisted suicide's statutory gatekeepers. Our skepticism has grown to outright distrust since the values of managed care have dominated the health care scene. Anyone who asserts that money will not influence the treatment options offered to people, or that the impact of out-of-pocket costs on a individual's family will not influence the individual's or their family, is at best unrealistic and at worst dishonest.

Pro-assisted suicide advocates call it "choice" but, with or without so-called safeguards, the so-called "autonomy" of assisted suicide is not being offered to healthy, non-disabled people. According to the U.S. Surgeon General, 16 of every 17 suicide attempts fail, and most don't try again. (U.S. Public Health Service, "The Surgeon General's Call to Action to Prevent Suicide," Washington, D.C.: U.S. Government Printing Office, 1999.) Assisted suicide is not about parity in the opportunity for suicide. It's about a government and a health care system guaranteeing that certain suicides don't fail. That's discrimination.

The wish for an easy and certain method of suicide under some circumstances is understandable. But that wish must be weighed against the certainty of increasingly routine medical killing of older and disabled people. Whether or not any one of us worries about inevitable abuses affecting us personally, the lives of those who will be affected are not an acceptable price for legalizing this practice.

Regardless of our abilities or disabilities, none of us should feel that we have to die to have dignity, that we have to die to be relieved of pain, or that we should die to stop burdening our families or society. For years you've heard from the right to die and the right to life movements. It's time to listen to the disability rights movement. We offer a very different vision, as well as the practical know-how and leadership to help build a society and a long term care system in which no one feels like a burden, and everyone has real choice, not the false "choice" of assisted suicide.

Dear Committee Members,

Frankly, I was a bit surprised to see this issue alive and well in Wisconsin. While I am not a medical professional, I do have some strong feelings about this issue. I will touch on my personal feelings as Ms. Coleman is more comprehensive in her paper on this issue.

I am not as familiar with this issue as I once was, when Dr. Kevorkian was running rampant; but the issue is still much the same. The bill has the potential to open some doors that are best left closed. Once the idea of assisting someone to kill themselves becomes "OK" it becomes much easier to broaden it out. Why were his victims predominately people with disabilities?

"Death with dignity" Looking at that phrase by itself is a bit scary; it can mean a lot of different things to a lot of people.

Assisted suicide is supposedly about terminal illness, as I believe this bill is supposed to address. However, who defines dignity? Is it the ability to die quietly - surrounded by your loved ones in the comfort of your own home?

It would seem that this is what dignity means for purposes of this legislation - what about life with dignity? The person with a disability who has struggled to stay in their own home, and then became sick because of inadequate resources and supports is now checked into a nursing home and sitting in a hallway with 30 other half dressed people who are facing the same "dignified" life style.

But, now that this person has become terminally ill, suddenly they are allowed to be dignified again? But only in their death, not their life. I mentioned this because I believe that this bill calls for 3 witnesses to the death request. However, in a facility, there need be only 1 witness. Is that because we find it so much easier to believe that a person doomed to a facility would request death as a preferable alternative to life in that situation? So much so we need only one witness to believe it? If we believe this, which many of us do- is it such a leap in logic to realization that we will be able to eliminate half the population in our nursing facilities? After all, that is what we hear now "People in nursing facilities are no longer capable of living in the community" Although personally, I don't believe it.

I realize that everyone says that there are safe guards in place, and this will not happen here, Doctor's know what they are doing, etc. It is the last one that scares me. After my injury my mother was told that I was terminal and for a while there if I had a chance to take your magic little pill, I may very well have. I am here today and can readily say that I am glad I did not have that chance. Some would say I do more with my "so called" limitation than many people with out disabilities are able to accomplish.

The legislation says that those requesting death must be informed of other options such as hospice, adequate pain relief etc. Adequate pain relief is an issue our culture has yet to come to terms with. Each of the legislators here should check in to see what the availability of hospice is in their respective districts. Lastly, as the managed care freight train comes directly towards the people with disabilities and seniors in this state I encourage you to make sure that not only are people informed of other options, but they are actually able to receive these options. As with everything in life, there is no magic bullet, nor is there a magic pill.

Steve Vanden

## **Senate Bill 151 (Wisconsin's assisted-suicide bill)**

### **Testimony before the Committee on Public Health, Senior Issues, Long Term Care and Privacy**

**January 23, 2008**

**Rita L. Marker, J.D.**

Good morning. My name is Rita Marker. I am an author, patient advocate, attorney and executive director of the International Task Force on Euthanasia and Assisted Suicide.

For more than twenty-three years, I have been deeply engaged in the debate about assisted-suicide and euthanasia from a public policy perspective.

I am here today to discuss the implications of Wisconsin's assisted-suicide proposal and the flaws in Oregon's assisted-suicide law upon which the Wisconsin bill is patterned.

#### **Physician-assisted suicide would be carried out in today's dysfunctional health care system and culture.**

Its proponents virtually always depict legalized assisted suicide as something that would take place within the context of a loving family, facilitated by a caring doctor who, after lengthy discussions with the patient, would write a prescription for lethal drugs to be used as a last resort.

But I ask you to consider the following:

According to the Wisconsin Department of Health & Family Services, 1 out of 11 people in the state are without health insurance at any given time. That, by definition, means that they may not have access to quality medical treatment, let alone have the luxury of lengthy, personal discussions with a physician. Maybe that is why we don't see poor people demanding the "right" to assisted suicide.

To make matters worse, even for those who have health insurance, time with a physician is greatly limited. Because physicians are forced to work within an economic system dominated by managed care and HMOs, their interaction with patients may be limited to 10 or 12 minutes a visit. Furthermore, even for people who have medical insurance, authorization often depends on cost effectiveness.

The cost of drugs for assisted suicide is under \$100. If assisted suicide becomes a legally accepted medical treatment, the economic force of gravity is obvious. What could be more cost effective than a prescription for assisted suicide?

Meanwhile, many families are under tremendous strain. At a time of rising gas prices, home foreclosures and general economic uncertainty, it would be foolhardy to ignore the role that finances would play when making life and death decisions. Furthermore, while we would all

like to believe that family means warmth, love and protection, we need to face the reality that dysfunctional families are not rare and elder abuse – much of it at the hands of a family member – is a fact of life.

Nonetheless, in Oregon, assisted suicide has been a medical treatment for ten years. That state's experience is touted as a model by assisted-suicide advocates who claim that the law's safeguards protect patients and that the annual official reports prove that there have been no problems or abuses.

However, statements made by individuals who have been involved in assisted suicide in Oregon – those who implement it, compile official reports about it, or prescribe the lethal drugs – clearly show that the law's safeguards are not protective and that effective monitoring is close to non-existent.

**Assisted suicide in Oregon is carried out behind a shroud of secrecy with non-enforceable guidelines and non-verifiable reports.**

**Annual reports unreliable**

- ♦ **All information in official reports is provided by those who carry out assisted suicide. There is no independent state oversight. If a doctor violates the law, he or she is unlikely to report the violation to the state.**

Under Oregon's law, doctors participating in assisted suicide must file reports with the state. The doctor first helps the person commit suicide and, afterwards, reports that his or her actions complied with the law. Then, that information is used to formulate annual reports. But, from the time the law went into effect, Oregon officials in charge of formulating annual reports have conceded that "there's no way to know if additional deaths went unreported."<sup>1</sup> A lead author of several official reports said that information received from doctors "is a self-report, if you will, of the physician involved."<sup>2</sup>

- ♦ **There are no penalties for non-reporting or for inaccurate or incomplete reporting.**
- ♦ **Complications or other problems associated with assisted suicide are almost impossible to determine.**

When asked if there is a systematic way of finding out and recording complications, a state official said, "Not other than asking physicians."<sup>3</sup> According to the last official report, physicians who prescribed the drugs for assisted suicide were present at only 21.5% of reported deaths.<sup>4</sup> Any information the absentee doctors provide might come from secondhand accounts<sup>5</sup> or may be based on guesswork.

- ♦ **The state does not have any authority to verify if reports made by assisted-suicide providers are accurate or complete. It also does not have the authority or the funding to track complications or abuse.**



A state official who was the lead author of most of Oregon's official reports said, "Not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves."<sup>6</sup>

- ◆ **Records used in annual reports are destroyed.**

According to one state official, "After we issue the annual report, we destroy the records."<sup>7</sup> Thus, there is no way to reexamine information if questions or concerns about an assisted-suicide death arise later.

*Safeguards are based on political calculations, not patient protection*

- ◆ **The waiting period between requests for assisted suicide and provision of the lethal prescription was based on political strategy.**

Oregon's law requires a fifteen-day waiting period between the first request and the provision of drugs for suicide. Kathryn Tucker, legal counsel of Compassion & Choices (the organization spearheading attempts to pass Oregon-type laws in other states), admitted that the waiting period was included to assure passage of the law. Referring to the waiting period, she explained that, after failing in several states, their strategy evolved:

"In my view, the Oregon measure, in some sense, became overly restrictive. It has a fifteen-day waiting period. And my own view of the federal constitutional claim is that *a fifteen-day waiting period would be struck down immediately* as unduly burdensome. As we've seen in the reproductive rights context, you can't have a waiting period of that kind of duration. But in the legislative forum, to pass, you need to have measures that *convince people* that it's suitably protective so you see a fifteen day waiting period."<sup>8</sup>

- ◆ **The required life expectancy of six months or less is both disingenuous and disregarded.**

Oregon's law requires that patients be diagnosed with a life expectancy of six months or less before they are eligible for assisted suicide. However, a physician who has been involved in Oregon assisted-suicide deaths numbering in double digits said that such life expectancy predictions are inaccurate. Dr. Peter Rasmussen, an advisory board member for Compassion & Choices of Oregon, dismissed the need for an accurate prognosis of life expectancy, saying:

"Admittedly, we are inaccurate in prognosticating the time of death under those circumstances. *We can easily be 100 percent off, but I do not think that is a problem.* If we say a patient has six months to live and we are off by 100 percent and it is really three months or even twelve months, I do not think the patient is harmed in any way...."<sup>9</sup>

♦ **Oregon's law permits doctors to help mentally ill or depressed patients commit suicide.**

A referral for counseling is only necessary if, in the opinion of the attending or consulting physician, the patient requesting assisted suicide may be suffering from a psychiatric or psychological disorder or depression *causing impaired judgment*.<sup>10</sup> If the counselor determines that the patient's judgment is not impaired from the mental illness or depression, the prescription for assisted suicide may be issued. In the last year for which reports are available, physicians reported referring only 4% of assisted-suicide patients for psychological or psychiatric evaluation to determine if they had impaired judgment.<sup>11</sup>

♦ **Widely reported abuses do not find their way into official reports.**

Kate Cheney died from assisted suicide even though her own physician and a psychiatrist determined that she was incapable of understanding what she was requesting and that her daughter was "somewhat coercive." Nonetheless, the drugs were finally prescribed after a managed care ethicist determined that she was qualified for assisted suicide.<sup>12</sup>

Michael Freeland, whose case was described in a paper presented at the American Psychiatric Association,<sup>13</sup> received lethal drugs for assisted suicide almost 2 years before he died a natural death -- meaning that he did not meet the requirement of a 6 months life expectancy. After receiving the drugs, he was hospitalized because he had become delusional but he was permitted to keep the prescription for assisted suicide.

♦ **There are no "safeguards" after the prescription is written. Physicians aren't required to keep track of patients who have received assisted-suicide prescriptions.**

According to one Oregon official, "Our job is to make sure that all the steps happened *up to the point the prescription was written*."<sup>14</sup> She said that the "law itself only provides for writing the prescription, *not what happens afterwards*."<sup>15</sup>

**The rationale for transforming assisted suicide from a crime into a medical treatment requires that the practice not be confined to self-administration by a terminally ill, competent adult.**

If assisted suicide is proclaimed by the force of law to be a good solution to the problem of human suffering then it is both unreasonable and cruel to limit it to the dying. Once we have changed assisted suicide from a bad thing to be prevented to, at least in some cases, a good thing to be facilitated, then it is easy to see how the early "safeguards" come to be seen as obstacles to be surmounted.

On what basis could one deny a good and compassionate medical treatment to those who are suffering from chronic conditions? Or from children? Or from those who never have been or are no longer competent?

How long would it be before the requirement of "self-administration" was deemed illogical and overly restrictive? What about the person who is physically unable to self-administer the lethal dose? After all, is there any other medical treatment that a physician can prescribe for but not administer to a patient?

One could legitimately ask why such expansion has not taken place in Oregon where assisted suicide has been practiced for ten years. The answer, in a word, is "expediency." Assisted-suicide proponents are admittedly well-meaning and committed. They are also well aware that moving too far, too fast will be counterproductive to achieving their goals.

This strategy was described recently in a *New York Times Magazine* cover story. Former Governor Booth Gardner, the spokesperson for a current campaign to legalize assisted suicide in Washington, said the restrictive assisted-suicide proposal (virtually identical to Oregon's law) is a compromise. According to the article:

"Gardner wants a law that would permit lethal prescriptions for people whose suffering is unbearable, a standard that can seem no standard at all; a standard that prevails in the Netherlands, the Western nation that has been boldest about legalizing aid in dying; a standard that elevates subjective experience over objective appraisal and that could engage the government and the medical profession in the administration of widespread suicide.... Gardner's campaign is a compromise; he sees it as a first step. If he can sway Washington to embrace a restrictive law, then other states will follow. And gradually, he says, the nation's resistance will subside, the culture will shift and laws with more latitude will be passed..."<sup>16</sup>

The current Wisconsin proposal is based on Oregon's assisted-suicide law. That "model law" is deeply flawed as a number of states have found when considering similar proposals. Since the passage of Oregon's law, 22 states (including Wisconsin) have considered proposals that are virtually identical to it. All have failed.<sup>17</sup>

I would ask that Wisconsin consider following their lead.

Endnotes:

- <sup>1</sup> Linda Prager, "Details emerge on Oregon's first assisted suicides," *American Medical News*, Sept. 7, 1998.
- <sup>2</sup> Testimony of Dr. Melvin Kohn before the House of Lords Select Committee on the Assisted Dying for the Terminally Ill Bill, *Assisted Dying for the Terminally Ill Bill [HL], Volume II: Evidence*. Apr. 4, 2005, p. 263, question 598. (Hereafter referred to as *HL*.) Available at: <http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf> (last accessed Jan. 17, 2008).
- <sup>3</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 263, question 597.
- <sup>4</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (<http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf>) The annual report states that the presence of the attending physician in 63 out of 292 reported deaths is 29%, however the calculation is mathematically inaccurate. The correct calculation is 21.5%.
- <sup>5</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, "Methods." (<http://www.oregon.gov/DHS/ph/pas/docs/Methods.pdf>)
- <sup>6</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 266, question 615.
- <sup>7</sup> *Ibid.*, p. 262, question 592.
- <sup>8</sup> Kathryn Tucker, speaking at Discovery Institute Conference, Seattle Pacific University, July 12, 1997. Transcript of videotaped presentation.
- <sup>9</sup> Testimony of Peter Rasmussen *HL*, p. 312, question 842. (Emphasis added.)
- <sup>10</sup> ORS 127.825 §3.03. (Emphasis added.)
- <sup>11</sup> DHS, "Ninth Annual Report on Oregon's Death with Dignity Act," March 8, 2007, Table I. (<http://www.oregon.gov/DHS/ph/pas/docs/yr9-tbl-1.pdf>)
- <sup>12</sup> Erin Barnett, "A family struggle: Is Mom capable of choosing to die?" *Oregonian*, Oct. 17, 1999.
- <sup>13</sup> N. Gregory Hamilton, M.D. and Catherine Hamilton, M.A., "Competing Paradigms of Responding to Assisted-Suicide Requests in Oregon: Case Report," presented at the American Psychiatric Association Annual Meeting, New York, New York, May 6, 2004. Available at: <http://www.pccf.oorg/articles/art28.htm> (last accessed Jan. 17, 2008).
- <sup>14</sup> Testimony of Dr. Katrina Hedberg, *HL*, p. 259, question 566. (Emphasis added.)
- <sup>15</sup> *Ibid.*, p. 259, question 567. (Emphasis added.)
- <sup>16</sup> Daniel Bergner, "Death in the Family," *The New York Times Magazine*, Dec. 2, 2007.
- <sup>17</sup> For a listing of failed assisted-suicide proposals see: <http://www.internationaltaskforce.org/usa.htm>.

For additional information, see: <http://www.internationaltaskforce.org> or contact:  
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800-958-5678

Good morning! I am appearing here today in support of Senate Bill 151. While I agree with the arguments that have been made in support of this bill, I won't bore you by repeating them. The reason that I have asked to speak at this hearing is to address one of the arguments that I have heard people make who are opposed to any legislation that would allow individuals to request medication for the purpose of hastening their death. Some people make the argument that: There would be no need for patients to hasten their deaths if patients are given adequate pain medication and if the delivery of other palliative care measures is improved. These people argue that state government should be focusing on improving palliative care for terminally ill patients instead of enacting death with dignity legislation, like Senate Bill 151. Although I agree that palliative care for terminally ill patients is important and needs to be continually improved, I know from sad personal experience that the best that palliative care has to offer is sometimes not good enough.

My husband died of esophageal cancer nearly two years ago. Shortly after he was first diagnosed, he underwent chemotherapy, radiation therapy and surgery to shrink and remove the tumor on his esophagus. As he was recovering from his surgery, his doctors and I soon realized that he was hypersensitive to the side effects of narcotic pain medications. He had terrifying hallucinations, extreme restlessness and anxiety attacks. He pulled out a drainage tube and IVs that had been inserted following the surgery. His doctors tried several different opiate pain killers, but they were never able to find one that worked well for him. His doctors finally used a spinal block to relieve his pain while he recovered from the surgery. Within a few years, however, the cancer reappeared in my husband's neck and lungs. In the last 7 months of his life, the tumor in his neck caused him ever increasing pain. The tumor in my husband's neck was too high on his spine for a spinal block to be used. His doctors tried to relieve his pain by once again prescribing various opiate pain medications and other medications to try to counteract the opiate's side effects, but the opiates never gave him much pain relief and as the doctors increased the dosage of the opiates in an unsuccessful attempt to relieve his pain, the side effects became horrible. The frightening hallucinations, the restlessness and the anxiety attacks returned and continued for months. In spite of his doctors' best efforts, my husband suffered a great deal in the last few months of his life. I believe strongly that he should have had the option to legally hasten his death. Simply seeking to improve palliative care is not the solution for all terminally ill patients. Medical science has its limits and I believe that patients should be allowed to make the decision to hasten their death if they find that their suffering can not be relieved by other means as death approaches.

Thank you for giving me the opportunity to present my views to your committee.

**Scott Harold Southworth  
District Attorney of Juneau County, Wisconsin**

**Testimony Before the Senate Committee on Public Health, Senior Issues,  
Long Term Care and Privacy on 2007 Senate Bill 151**

**January 23, 2008**

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Mr. Chairman,

My name is Scott Harold Southworth, and I serve as the District Attorney of Juneau County. I'm also the proud father of a disabled Iraqi orphan who suffers from cerebral palsy.

I vehemently oppose SB 151 and its legalization of assisted suicide because it will target the poorest, weakest and most vulnerable members of our society for state-sponsored murder.

It takes very little prodding to convince someone suffering from a debilitating or painful disease that death remains their best and only hope. Thus, assisted suicide is merely euthanasia dressed in sheep's clothing. Most importantly, the only real difference between euthanasia and genocide is the number of victims who die at the hands of those who want a particular group of people removed from society.

Genocide begins with less insidious acts, and the targets of persecution are always those without power: the disabled, racial and ethnic minorities, religious minorities and political dissidents. For example, the Nazi Holocaust began with laws requiring Jews to wear the Star of David on their shoulder, scientific studies on the disabled, and the compiling of the names of known homosexuals. Those initial efforts then blossomed into the outright murder of Jews, Slavic people, gay men, Jehovah's Witnesses, political dissidents, Christian leaders, and the physically or mentally disabled. Millions of people died as a result of laws designed to make German society more "comfortable."

Throughout history, hate and bigotry spurred laws in other nations around the world allowing for the near destruction of whole cultures, including Africans at the hands of Western slave traders, Albanian Muslims at the hands of the Serbs and the present-day genocide of Christians in the Sudan at the hands of Islamic extremists.

Mr. Chairman, I have no doubt that you abhor the idea of genocide and that you intend for this legislation to provide comfort to those suffering from a disease.

However, your intentions cannot control the evil that this legislation invites. Once the Pandora's Box of assisted suicide, euthanasia and genocide is opened, it is difficult – if not impossible – to close.

As a district attorney, I can assure you that this legislation will require extraordinary investigative and prosecutorial resources as we attempt to root out those who violate their Hippocratic Oath in order to murder someone else. As the father of a disabled Arab child, I am frightened by the message this legislation sends to the weak, the vulnerable and the minorities of our society.

Assisted suicide is the seed of genocide, and we must remain vigilant in order to protect the dignity of every person, including those of every race, ethnicity, religious belief, sexual orientation, political affiliation, and mental or physical handicap. If we do not protect everyone, we cannot protect anyone.

Gentlemen, if this bill ever comes up for a vote, I urge you to vote no. However, I would ask you, Mr. Chairman, to reconsider your position on this issue. In your capacity as an elected legislator, you have the power to serve as a voice for all minority groups. I urge you to retract this bill from legislative consideration and take a stand on the side of life.

Thank you.

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**Schwantes, Nathan**

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**From:** wendy lundberg [wklundberg@hotmail.com]  
**Sent:** Tuesday, January 22, 2008 3:29 PM  
**To:** Sen.Carpenter  
**Subject:** SB 151

Dear Senator Carpenter,

It has come to my attention that tomorrow a public hearing on the physician-assisted suicide bill, SB 151 will be held in Madison. This is a measure introduced by State Representatives Fred Risser and Frank Boyle. Although I am unable to be in attendance to testify, I am writing to register my opposition to this proposed legislation.

I am a practicing physician in Fond du Lac specializing in medical oncology and hematology for the past seventeen years. I also spent six years on active duty in the United States Air Force in the practice of internal medicine and have experience in missionary medical work in West Africa, Russia, and Mongolia. In recent years I have also served as a part-time faculty member at the Medical College of Wisconsin and Zablocki Veterans Administration Medical Center in Milwaukee.

My practice in cancer medicine involves treating and counseling patients with life-threatening illnesses on a daily basis. I can recall only perhaps two patients over my career that have inquired about physician-assisted suicide. The vast majority of my patients face death and dying with courage and dignity, allowing the natural history of the malignancy to run its course. Our responsibility as physicians is to alleviate suffering and prolong life as much as it is in our power to do so and to "first do no harm." Sometimes in the practice of oncology we can cure disease but for many, if not most of our patients, treatments are not curative but palliative. Palliative care as a specialty and hospice care for dying patients have made great strides over the past 20 years. As a result few patients have intractable pain or other symptoms at the end of life that represent intolerable suffering.

Advocates of physician-assisted suicide are sincere and well-intentioned. I am convinced, however, that this proposal is first, unnecessary and second, dangerous for the citizens of this state. No amount of precautions and safeguards can protect patients from potential abuses, mistakes, and misapplication of this type of legislation and the power it can exert over life and death. We must continue to compassionately provide for and protect the most vulnerable in our society including patients with terminal illnesses. It is neither moral nor merciful to end a person's life prematurely in an attempt to alleviate their suffering. There are better alternatives which I have witnessed firsthand.

Sincerely,  
Joel Lundberg M.D. FACP  
Assistant Clinical Professor, Medical College of Wisconsin  
"Best Doctors in America"

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## Schwantes, Nathan

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From: smh@maqs.net  
Sent: Wednesday, January 23, 2008 8:33 AM  
To: Sen.Carpenter  
Subject: SB 151

Importance: High

Dear Senator Carpenter,

My name is Susan M. Haack, MD. I am a board certified ob-gyn with a Master's in bioethics. I practice at Hess Memorial Hospital in Mauston and serve on the WMS Ethics committee. I wish to register my opposition to SB 151.

We have lost sight of the goals: medicine is a healing art and profession with the goal of caring compassionately for the vulnerable and ill. A secondary goal is prevention of illness. To force medicine to cater to the autonomous desires of a few will be to destroy medicine as we know it.

A "death with dignity" law will further undermine the already tenuous physician-patient relationship which has traditionally been built on trust. Our loyalties are already divided by legal and financial constraints. Our ability to be patient advocates is increasingly difficult. With the rising costs of end-of-life care, it will be far too easy for insurance companies to "encourage" physicians to offer to end such costly and "inconvenient lives." And while such a law will supposedly allow some to have their desires met, it will soon become an expectation for all who at the end of life feel that their lives are a burden to others. As human beings we are in our most vulnerable state at the end of our lives. It is then that we need a trusted physician to walk compassionately with us through that last leg of our journey, not offering to end our inconvenient lives.

And just as with the current controversies over abortion, once such a law becomes a patient right, it will become a physician obligation and expectation. Physicians will be required to "offer it" as part of "informed consent," even if they disagree. And such offers will only reinforce the vulnerable patient's sense of burden and obligation to end that burden.

In summary, a "Death with Dignity" law will only serve to destroy medicine, the physician-patient relationship, and further undermine the cohesiveness of our society where everyone is seen as an equal and valuable member. And it will diminish us as human beings. It is animals that abandon their weak and vulnerable.

Respectfully submitted,  
Susan M. Haack, MD, MA, FACOG  
Mauston, WI

**Statement of James L. Greenwald to the Senate Public Health Committee on Senate Bill 151, the Death with Dignity Act.**

My name is James L. Greenwald. I'm 77 years old and I live in Madison. I am a retired attorney. I spent the larger part of my career as an attorney in Wisconsin state government. I am a member of Compassion & Choices and was a member of the Hemlock Society before the merger.

Many supporters of physician aid in dying have seen their parents, spouses, relatives and friends die difficult and protracted deaths. They don't want to die that way themselves and they don't want others to have to die that way. I support the Bill for those reasons too.

I also support Senate Bill 151, the Death with Dignity Act, because it is in the best tradition of the constitutional principle of personal liberty. It is about that principle that I speak today.

This principle is not new and has been fought over the years by opponents who believe that their own moral precepts should be mandated for everybody.

The Fourteenth Amendment to the U.S. Constitution provides that no person shall be deprived of liberty without due process of law. The U.S. Supreme Court struck down a Connecticut statute prohibiting the sale of contraceptives holding that couples had the personal liberty to have sexual intercourse for purposes other than procreation. Griswold, 381 U.S. (1965). It struck down a Virginia law prohibiting a person from marrying a person of a different race. Loving, 388 U.S. (1967). It recognized the right of a woman to be free from government interference in deciding matters as personal as whether to continue an unwanted pregnancy to term. Roe v. Wade, 410 U.S. (1973). It recognized that a person has a liberty interest under the Due Process Clause in refusing unwanted medical treatment. Cruzan v. Missouri Dept. of Health, 497 U.S. (1990).

Nancy Cruzan suffered severe injuries in an automobile accident. For six years, she was in a persistent vegetative state and her doctors said she has no hope of improvement in her condition. Her parents requested that artificial nutrition and hydration be terminated, but the state hospital refused.

Justice Brennan said in his separate opinion,

"There are ... affirmative reasons why someone like Nancy might choose to forgo artificial nutrition and hydration under these circumstances. Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence. 'In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve.' (Case reference omitted) [The Court found] the subject of the proceeding 'in a condition which he has indicated he would

consider degrading and without human dignity' and holding that 'the duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity.'

Brennan continued, "Another court, hearing a similar case, noted:

'It is apparent from the testimony that what was on the patient's mind was not only the invasiveness of life-sustaining systems, such as the nasogastric tube, upon the integrity of his body. It was also the utter helplessness of the permanently comatose person, the wasting of a once strong body, and the submission of the most private bodily functions to the attention of others.' (citation omitted)

"Such conditions are, for many, humiliating to contemplate, as is visiting a prolonged and anguished vigil on one's parents, spouse and children. A long, drawn-out death can have a debilitating effect on family members. (citations omitted) For some the idea of being remembered in their persistent vegetative states rather than as they were before their illness or accident may be very disturbing"

Those quotations from Justice Brennan's opinion are on pages 310 – 312 of the Court's decision in the Cruzan Case.

Brennan shows a great deal of empathy for someone in Nancy Cruzan's situation. He would undoubtedly have the same empathy for someone who was just told by his doctor that his illness was terminal and that he had less than 6 months to live. Such a terminally ill person would be rightly apprehensive as to what lie ahead for him and what his options were. He might wish he had the option of physician aid in dying and a hastened death if the dying process became unbearable for him.

Brennan addressed the state's claimed interest in keeping Nancy Cruzan alive. He said:

"The only state interest asserted here is a general interest in the preservation of life. But the State has no legitimate general interest in someone's life, completely abstract from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment. 'The regulation of constitutionally protected decisions ... must be predicated on legitimate state concerns other than disagreement with the choice the individual has made ... Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity.' (citation omitted)" At page 313.

Why shouldn't a terminally person be entitled to the same right to death with dignity that a person who can not live without life support? The U.S. Supreme Court in Glucksberg, 65 LW (1997) said that such a constitutional right does not exist. Whether you are 6 month away from death in one case or only being kept alive by

medical intervention in another case, an individual should have the freedom to choose his own time to end his life. The Court said it was up to the states to create a statutory right to physician aid in dying. The bill being considered by the Committee, the Wisconsin Death with Dignity Bill, creates such a right for the terminally ill.

. Opponents of the Wisconsin bill will use the terms "suicide" and "killing". The term "suicide" hardly seems appropriate to apply to a person who is already dying. A terminally person does not want to die, he wants to live. Unfortunately, this disease is responsible to his dying. What he wants to do is to relieve his suffering. The term "killing" is totally inappropriate since under the bill a doctor does not kill his patient. The patient is not required to use the doctor's medicine. The purpose of the bill is not to kill people but to give patients, who are terminally ill, the option of ending their suffering, if they choose to do so. In addition, opponents claim that minorities, the disabled and women will be put at risk by a new statutory right, even though it contains all of the safeguards contained in the Oregon Law. The experience under Oregon Death with Dignity Law over the last 10 years proves that such claim is unfounded.

In my view, Wisconsin must give meaning to the concepts of personal freedom and personal liberty. The bill is a permissible bill. It does not mandate that a person facing death must act in a particular way. It does not mandate that a person, who believes for religious reasons that it is wrong for a dying patient to hasten his death, use the provisions of the law. Such a person can simply wait to succumb to his disease however long that takes and whatever suffering he endures. The bill allows the dying a choice.

The bill gives all of us when our time comes the right to choose when to drop the curtain. The bill gives dying patients the right to choose to hasten their deaths so as to try to preserve the last vestiges of their dignity and humanity.

Testimony of Julie A. Grimstad, Executive Director  
Life is Worth Living, Inc.  
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January 23, 2008

Dear Chairman Carpenter and Members of the Senate Committee on Public Health,  
Senior Issues, Long Term Care and Privacy:

Thank you for this opportunity to testify in opposition to SB 151, which would legalize physician-assisted suicide (PAS) in Wisconsin.

Suicide by any other name is still suicide.

This bill declares, "Taking medication under a fulfilled request for medication under this chapter does not, for any purpose, constitute a suicide." This is a blatant lie. *Webster's Third New International Dictionary* (unabridged) defines suicide as "the act...of taking one's own life voluntarily and intentionally." At least let's be honest

A request for medical assistance to kill oneself must be understood as a cry for help, not as a choice to be honored.

Suicidal thoughts and expressions often arise from difficult situations of suffering, loneliness, lack of economic prospects, depression and anxiety about the future. Add a serious illness to any of these difficulties and a person is particularly vulnerable to the suggestion that he or she might be better off dead. That suggestion is inherent in a law that permits a physician to provide a patient with the means to commit suicide.

Advocates of PAS often cite Oregon's 10-year experiment with PAS to reassure us there is nothing to fear. Contradicting that claim is a 2006 report by British palliative care expert Dr. David Jeffrey (available at [www.wcmt.org.uk/reports](http://www.wcmt.org.uk/reports)). During the course of conducting research, Dr. Jeffrey uncovered a number of disturbing unreported PAS cases in Oregon, including:

- A patient was told by his doctor that "you have ALS...this is awful...you should consider physician-assisted suicide." The patient was "devastated."
- A patient with cancer was told by a doctor that "it was going to be a painful way to die" and advised him to take advantage of the PAS law. The patient took the lethal drugs, but did not die quickly. His wife couldn't handle the situation, so a pro-assisted suicide organization sent two men to sit with the man until he died the next morning. The wife became profoundly depressed and attempted suicide herself.

How voluntary is PAS when you are not offered any hope or other options? And, when so many people have inadequate access to medical care, it is cruel to offer death as a "choice." Let's fix our medical system, not eliminate those who need medical care.

If PAS for those with terminal illness is legalized, the "right to die" is likely to become a perceived "duty to die."

Family members and friends who support the suicide of a terminally ill patient reinforce the notion that the person's life has lost all meaning and is a "burden." Furthermore, with concern mounting over containing medical costs, seriously ill patients are made to view themselves as drains on society. Legalizing PAS will not ensure death with dignity; rather, it will contribute to the devaluation of the lives of people who require "too many resources." I fear that suicide will become the logical expectation of a system that prizes cost savings over people.

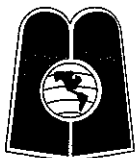
Advocating death as a solution to pain is unethical and extreme.

The American Medical Association adamantly opposes transforming assisted suicide into a medical treatment. The Hippocratic Oath contains this promise: "I will give no deadly medicine to anyone if asked, nor suggest such counsel."

We have the medicine and technology to effectively control pain. While some barriers exist to their implementation, efforts should be made to remove those barriers, not to legalize PAS. Instead of trying to legalize killing patients who are in pain, legislation should be aimed at making sure all physicians are taught, and use, effective pain management.

Moreover, SB 151, modeled after Oregon's law, merely requires that the patient be diagnosed to have a disease that will cause death within six months. It does not mention pain as a requirement for receiving a prescription for a lethal dose of drugs. Oregon physicians who have assisted suicides report that most patients did not seek PAS because of pain, but because they feared becoming a burden, being unable to engage in enjoyable activities, and other non-pain-related concerns.

Bottom line: Legalizing PAS does not change a form of homicide into a medical treatment; rather, it turns the law into an accessory to homicide.



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of America**  
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Rabbi Yehiel M. Kalish  
*National Director of  
Government Affairs*

TESTIMONY

**TO:** Honorable Members of the Committee on Public Health, Senior Issues, Long Term Care and Privacy

**FROM:** Sheba Seif, Legislative Assistant, Agudath Israel of America, Midwest Region.

**SUBJECT:** SB 151 – Death with Dignity

**DATE:** January 23, 2008

Mister Chairman and Honorable Members of the Committee,

My name is Sheba Seif. I live in Chicago, Illinois and I work as a Legislative Assistant for Agudath Israel of America, Midwest Region. Agudath Israel is the largest public policy and social services organization in the Orthodox Jewish community. With national headquarters in New York, a branch in Washington, D.C., and the Midwest Regional Headquarters located in Skokie, Illinois, we represent thousands of constituents across the United States, including Milwaukee.

Thank you for giving me the opportunity to testify before you as an opponent to SB 151. This bill permits an individual to request medication from his/her attending physician for the purpose of ending the individual's life.

It is a basic principle of Jewish law and ethics that man does not possess absolute title to his life or body. Agudath Israel believes that recognition of this teaching has served as one of the pillars of civilized societies throughout the generations. The reason we are speaking out on this bill, however, is due to the dangerous outcomes that legalizing assisted suicide will have on public policy.

Our reasoning includes the following:

- ◆ **CREATION OF A DUTY TO DIE:** This bill will create a duty to die in a vulnerable population. A patient may be forced to weigh his/her right to live against the burden he/she places upon family, friends and society by choosing to live. Such burdens can be either financial or emotional and can greatly influence someone whose illness has already placed him/her in a compromised, dependent, and vulnerable position.

- ◆ **POTENTIAL FOR ABUSE:** Legalizing assisted suicide creates an enormous potential for abuse, despite the “safeguards” which purportedly would prevent such abuses. For example:
  - The increasing costs of end of life healthcare would provide an incentive for caretakers and/or health insurance companies to “promote” assisted suicide, especially to the poorest and most vulnerable of our patients; those without the means and the stamina to withstand pressure, both subtle and not so subtle.
  - The safeguards require the individual to be acting voluntarily in a request for medication to end his/her life. How will anyone know if the patient is acting voluntarily or if he/she is being coerced? Even the patient may not realize that he/she is being coerced.
  - Once the medication has been delivered, family members may take matters into their own hands. There are no provisions in this bill for overseeing and monitoring the administering of the medication.
  - The provision requiring the referral of the individual for review and counseling makes no mention as to the number of sessions required in order for the psychiatrist or psychologist to fully address the situation. The infrequency of psychiatric evaluation or no counseling evaluation at all, renders the provision of informed decision uncertain.
- ◆ **ARE WE TARGETING THE RIGHT POPULATION?** SB 151 proposes that only terminally ill patients may be assisted in ending their life with the assistance of a physician. It would seem that the chronically ill or persons with a disability, who are looking at many years of suffering with no hope of palliation, are more in need of an “out” than the terminally ill. Nevertheless, the legislature recognizes that it would be unethical, and in fact criminal, to advocate assisted suicide for these groups. Clearly, the legislature should not be deciding who has a right to end their life and who does not.
- ◆ **INVOLVING PHYSICIANS IN ASSISTED SUICIDE:** Assisted suicide presents many problems for the medical profession. Physicians have been taught to save life and make life more comfortable for their patients. Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own Hippocratic mandate and undermine public confidence in the medical profession.

Section 156.07 (9) of SB 151 states that if a physician refuses to fulfill the requestor’s request for medication, he must make a good faith attempt to transfer the requestor’s care and treatment to another physician who will fulfill the requestor’s request for medication. “Doctor shopping” will ensure that the patient’s request be fulfilled - if not by one doctor, then by another!

A request for assisted suicide should be viewed as a cry for help, and should invite compassion and care, not a lethal prescription.

Thomas Jefferson wrote, “[T]he care of human life and happiness, and not their destruction, is the first and only legitimate object of good government.”

Agudath Israel of America urges you to vote against this bill.

Thank you for your time. I am available for any questions.

Sheba Seif

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